Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: May 24, 2023	
Inspection Number: 2023-1094-0005	
Inspection Type: Critical Incident System	
Licensee: Lutheran Homes Kitchener-Waterloo	
Long Term Care Home and City: Trinity Village Care Centre, Kitchener	
Lead Inspector Helene Desabrais (615)	**Inspector Digital Signature**
Additional Inspector(s) Yami Salam (000688) Nuzhat Uddin (532) Craig Michie (000690) Kaitlyn Puklicz (000685)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 3, 4, 5, 9, 10, 11, 12, 15, 16, 2023.

The following intake(s) were inspected:

- Intake: #00007858, related to falls prevention;
- Intakes: #00016084, #00018198, #00018933, #00019292, #00019395, #00020327, #00020335, #00020801, #00021055, #00022334, #00022444, #00086196, related to prevention of abuse and neglect;
- Intake: #00019770, related to resident care and support services.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect a resident from verbal abuse by a staff member.

"Verbal abuse" means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident. O. Reg. 246/22 s. 2 (1).

Rationale and Summary

On two separate days, two staff members were providing care to a resident who exhibited responsive behaviours. One staff member witnessed the other staff verbally threatening the resident.

The home's internal investigation report documented that the staff member had reported to the Assistant Director of Care (ADoRC) that the resident's response to the incidents was not consistent with their typical behaviour, demonstrating the incident had an impact on the resident.

The ADoRC stated that their investigation concluded that the resident had been verbally abused by the staff member.

Sources: Critical Incident report, home's internal investigation report, prevention of abuse/neglect training documentation for a staff member, a resident clinical records, interview with the ADoRC and two staff members.

[000688]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that an allegation of improper/incompetent treatment of two residents were immediately reported to the Director.

Pursuant to s.154 (3), the licensee is vicariously liable for a staff member failing to comply with subsection 28 (1).

Rationale and Summary

A) Two staff members were providing care assistance to a resident. At that time, one staff member alleged that the resident demonstrated responsive behaviours and appeared to be experiencing pain to the care being provided; however, the other staff member insisted to provide the care. The staff member said the resident was distressed and they felt that the other staff member actions did not respect the resident's rights to proper care. Those allegations were reported to the Director five days later.

The Director of Care (DOC) stated that the staff member should have reported the alleged improper/incompetent care immediately.

The home’s failure to report the improper/incompetent treatment of the resident immediately delayed the home’s ability to investigate the allegations and may have delayed the Director in responding to the incident.

Sources: Critical Incident, resident’s clinical records, home’s investigation, interview with the DOC.

[000685]

B) On a specific day, the home received a written complaint from a resident’s family member related to alleged improper care of a resident.

The Assistant Director of Resident Care (ADoRC) stated that their investigation concluded it was founded. The incident was reported by the home to the Director five days later and should have been immediately reported.

Sources: Critical Incident report and an interview with the ADoRC.

[000688]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that the alleged verbal abuse of a staff member to a resident was immediately reported to the Director.

Pursuant to s.154 (3), the licensee is vicariously liable for a staff member failing to comply with subsection 28 (1).

Rationale and Summary

On two separate days, two staff members were providing care to a resident who exhibited responsive behaviours. One staff member witnessed the other staff member being verbally aggressive towards the resident while providing care. The staff member reported those allegations three days later.

The Assistant Director of Resident Care (ADoRC) stated that the staff member was expected to report the alleged verbal abuse immediately.

The home’s failure to report the alleged verbal abuse of the resident immediately delayed the home’s ability to investigate the allegations and may have delayed the Director in responding to the incident.

Sources: Critical Incident report, home’s investigation, resident’s clinical records, prevention of abuse/neglect training for a staff member, interviews with the ADoRC, and three other staff members.

[000688]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 25.

Rational and Summary

The licensee has failed to ensure that a resident's right to be provided with care and services based on a palliative care philosophy was fully respected and promoted.
In accordance with O. Reg 246/22 s. 61 (1), the licensee is required to ensure resident's palliative care needs are met.

A resident was diagnosed End-of-Life by the home's physician. A day after, the resident's substitute decision maker (SDM) expressed concern that the resident had not received the required end-of-life care to a Registered Nurse (RN) who confirmed the care had not been provided. The home's investigation documented that staff did not provide the resident the required end-of-life care over an eight hour period.

A staff member stated that after the SDM complained, they witnessed that the resident had not received the required end-of-life care. The staff member said that the resident did not have a palliative plan of care and that staff may not have been aware of the resident's end-of-life care needs. The resident passed away seven days later, and no care and services based on a palliative care philosophy had been provided to the resident.

The Director of Care (DOC) stated that the resident's palliative care needs for a plan of care had not been assessed; therefore, the resident was not provided with care and services based on a palliative care philosophy.

Sources: Resident's clinical records, the home's Critical Incident, the home's investigation, interviews with a staff member and the DOC.

[615]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with FLTCA, 2021 s. 58 (4) b.

The licensee has failed to ensure that strategies were implemented to respond to a resident when demonstrating responsive behaviours.

Rationale and Summary

Two staff members were providing care assistance to a resident. At that time, one staff member alleged that the resident demonstrated responsive behaviours to the care being provided; however, the other staff member insisted to provide the care.

The resident's plan of care related to responsive behaviours directed staff to specific interventions when the resident demonstrated responsive behaviours; however, these strategies were not implemented by the staff member.

Sources: Resident's clinical records, Critical Incident, and an interview with a staff member.

[000685]

WRITTEN NOTIFICATION: General Requirements

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to comply with their Pain Management Program for a resident.

In accordance with O. Reg. 246/22 s. 11 (1)(b), the licensee is required to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Specifically, staff did not comply with the home's policy "Pain Management Policy", dated April 2023, which was included in the licensee's Pain Management Program. The Policy directed registered staff that all identified concerns were to be reported to the charge nurse for assessment. The registered staff to assess a resident's pain, using a clinically appropriate pain assessment tool, when there was a change in condition, or with the onset of pain, or the resident stated pain severity was moderate to high (4/10 or higher numerically). The assessment was to be documented on PointClickCare (PCC).

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Rationale and Summary

A resident was receiving care assistance from two staff members. One staff member documented in Point Click Care (PCC) that the resident had demonstrated responsive behaviours and appeared to be in pain. A record review identified that neither staff members notified a registered staff of the resident's pain, and consequently, no pain assessment was completed for the resident.

The home's failure to have the resident assessed promptly by a registered staff when signs of pain were identified led to a delay in interventions to relieve the resident's discomfort.

Sources: Resident's clinical records, the home's Pain Management Policy #1.02. (Last reviewed April 2023), Critical Incident report, and an interview with a staff member.

[000685]

COMPLIANCE ORDER CO #001 Required Programs

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a).

The Licensee has failed to comply with s. 53(1) 4, of O.Reg.246/22.

The licensee shall:

a) Provide all registered staff education on the home's pain management policy related to identifying, assessing, and managing pain.

b) Document the education including the date, format and staff attending the training, including the staff member who provided the education.

c) Conduct weekly audits for one month following the training or until compliance is achieved to ensure that registered staff are identifying, assessing, and managing a residents' pain on a resident's home area.

d) Written documentation of the audit including the person who conducted the audit, what was reviewed in the audit, the date the audit was conducted, the outcome of the audit, and corrective actions taken must be maintained in the Home.

Grounds

The licensee has failed to ensure that the home's pain management program was implemented in order to manage a resident's pain.

In accordance with O. Reg. 246/22 s. 11 (1)(b), the licensee is required to ensure that there is a policy in place for their Pain Management Program, that includes ways to identify and manage pain of a resident, and that it is complied with.

Specifically, staff did not comply with the home's policy "Pain Management Policy", dated April 2023, which was included in the licensee's Pain Management Program. The Policy directed registered staff to assess a resident's pain, using a clinically appropriate pain assessment tool, when there was a change in condition, or with the onset of pain, or the resident stated pain severity was moderate to high (4/10 or higher numerically). The assessment was to be documented on PointClickCare (PCC).

A staff member documented that they informed a registered staff member that a resident was experiencing a new pain. The resident rated their pain a level eight out of 10. The resident did not receive a pain assessment by a registered staff member. There was no assessment or management of the resident's pain until the next morning when they were sent to the hospital and diagnosed with an injury.

The Director of Care (DOC) and a Registered staff said that when pain was reported a pain assessment should be completed using a clinically appropriate pain assessment tool and documented in PCC.

The home's failure to have the resident assessed promptly by a registered staff when signs of pain were identified led to a delay in interventions to relieve the resident discomfort.

Sources: Critical Incident report, a resident's clinical records, the home's Pain Management Program Policy #1.02. (Last reviewed April 2023) and interviews with three staff members.

[000690]

This order must be complied with by June 30, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding

the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.